

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2025			Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/24/2022 2:04 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	0	25.00	
						Urban/Rural	St	Date of Geogra		
						1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	
						Beginning:		Ending:		
						1.00		2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
						Y/N		Y/N		
						1.00		2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N		N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N		N	40.00	
						V	XVIII	XIX		
						1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N		N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N		N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N		N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N		N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N				59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00		
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
		1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
						1.00			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
				Unweighted FTEs Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
				1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		Y	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06		
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N	105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	108.00		
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0043	140.00

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			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part II Date/Time Prepared: 1/24/2022 2:04 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			2.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/17/2021	Y	12/17/2021		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part II Date/Time Prepared: 1/24/2022 2:04 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		FREEMAN	41.00
42.00	Enter the employer/company name of the cost report preparer	TFG CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2256101100		MFREEMAN@TFGCONSULTING.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-2
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	41	14,965	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		41	14,965	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		41	14,965	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		41				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,276	0	9,582			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,276	0	9,582			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	5,276	0	9,582	0.00	85.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	85.00	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	221	0	373	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		221	0	373	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00						25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00						25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00						25.40
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-3
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	5,498,097	0	5,498,097	176,706.00	31.11
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		0	0	0		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-3
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,096,350	0	1,096,350	31,740.00	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	106,443	0	106,443	4,181.00	41.00
42.00	Social Service	17.00	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-3
Part III
Date/Time Prepared:
1/24/2022 2:04 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	5,498,097	0	5,498,097	176,706.00	31.11	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	5,498,097	0	5,498,097	176,706.00	31.11	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	5,498,097	0	5,498,097	176,706.00	31.11	6.00
7.00	Total overhead cost (see instructions)	1,202,793	0	1,202,793	35,921.00	33.48	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 1/24/2022 2:04 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			58,385 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 8.02
8.03	Health Insurance (Purchased)			210,693 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			118,077 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			460,922 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			848,077 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,138,363	1,138,363	0	1,138,363	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	848,077	848,077	0	848,077	4.00
5.00	00500	1,096,350	3,776,563	4,872,913	0	4,872,913	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	0	151,754	151,754	0	151,754	7.00
8.00	00800	0	39,946	39,946	0	39,946	8.00
9.00	00900	0	183,602	183,602	0	183,602	9.00
10.00	01000	0	244,398	244,398	0	244,398	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	106,443	44,577	151,020	0	151,020	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,817,138	1,223,470	5,040,608	0	5,040,608	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	286,101	286,101	0	286,101	50.00
54.00	05400	655	155,434	156,089	0	156,089	54.00
60.00	06000	0	273,532	273,532	0	273,532	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	362,885	512,012	874,897	0	874,897	65.00
66.00	06600	90,398	101,463	191,861	0	191,861	66.00
67.00	06700	0	167,801	167,801	0	167,801	67.00
68.00	06800	0	80,964	80,964	0	80,964	68.00
71.00	07100	24,228	0	24,228	0	24,228	71.00
73.00	07300	0	1,296,987	1,296,987	0	1,296,987	73.00
74.00	07400	0	235,557	235,557	0	235,557	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		5,498,097	10,760,601	16,258,698	0	16,258,698	118.00
NONREIMBURSABLE COST CENTERS							
200.00		5,498,097	10,760,601	16,258,698	0	16,258,698	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-177	1,138,186	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	848,077	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,519,612	3,353,301	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	151,754	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,946	8.00
9.00	00900	HOUSEKEEPING	0	183,602	9.00
10.00	01000	DIETARY	0	244,398	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-191	150,829	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
18.00	01850	RECREATIONAL THERAPY	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	5,040,608	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	286,101	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	156,089	54.00
60.00	06000	LABORATORY	0	273,532	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	874,897	65.00
66.00	06600	PHYSICAL THERAPY	0	191,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	167,801	67.00
68.00	06800	SPEECH PATHOLOGY	0	80,964	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,228	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,296,987	73.00
74.00	07400	RENAL DIALYSIS	0	235,557	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,519,980	14,738,718	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,519,980	14,738,718	200.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-7
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	110,439	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,068,337	172,467	0	172,467	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,178,776	172,467	0	172,467	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,178,776	172,467	0	172,467	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	110,439	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,240,804	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	1,351,243	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	1,351,243	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-7
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	460,599	636,574	2,903	27,291	10,996	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	460,599	636,574	2,903	27,291	10,996	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,138,363				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,138,363				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-7
Part III
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	460,422	636,574	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	460,422	636,574	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,903	27,291	10,996	0	1,138,186	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,903	27,291	10,996	0	1,138,186	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-177	CAP REL COSTS-BLDG & FIXT	1.00		9	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-723,456				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-300,031				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests		0		0.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-191	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00
33.00 ADVERTISING	A	-58,632	ADMINISTRATIVE & GENERAL	5.00		0	33.00
34.00 BAD DEBT EXPENSE	A	-437,493	ADMINISTRATIVE & GENERAL	5.00		0	34.00
35.00 MISC INCOME		0		0.00		0	35.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,519,980				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/24/2022 2:04 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HO OPERATING	1,481,628	1,781,659 1.00
2.00	0.00			0	0 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,481,628	1,781,659 5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	F		0.00	ACADIANA MANAGEMENT GROUP	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/24/2022 2:04 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-300,031	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-300,031			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MANAGEMENT COMPANY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-2

Date/Time Prepared:
1/24/2022 2:04 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	762,336	685,936	76,400	211,700	382	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			762,336	685,936	76,400		382	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	38,880	1,944	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			38,880	1,944	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	38,880	37,520	723,456		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	38,880	37,520	723,456		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,138,186	1,138,186			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	848,077	0	0	848,077	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,353,301	118,196	0	169,111	3,640,608
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	151,754	0	0	0	151,754
8.00 00800	LAUNDRY & LINEN SERVICE	39,946	0	0	0	39,946
9.00 00900	HOUSEKEEPING	183,602	0	0	0	183,602
10.00 01000	DIETARY	244,398	0	0	0	244,398
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	150,829	21,753	0	16,419	189,001
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
18.00 01850	RECREATIONAL THERAPY	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,040,608	866,773	0	588,790	6,496,171
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	286,101	0	0	0	286,101
54.00 05400	RADIOLOGY-DIAGNOSTIC	156,089	0	0	101	156,190
60.00 06000	LABORATORY	273,532	0	0	0	273,532
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	874,897	20,272	0	55,975	951,144
66.00 06600	PHYSICAL THERAPY	191,861	10,978	0	13,944	216,783
67.00 06700	OCCUPATIONAL THERAPY	167,801	10,978	0	0	178,779
68.00 06800	SPEECH PATHOLOGY	80,964	10,910	0	0	91,874
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,228	78,326	0	3,737	106,291
73.00 07300	DRUGS CHARGED TO PATIENTS	1,296,987	0	0	0	1,296,987
74.00 07400	RENAL DIALYSIS	235,557	0	0	0	235,557
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	14,738,718	1,138,186	0	848,077	14,738,718
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	14,738,718	1,138,186	0	848,077	14,738,718

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,640,608					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	49,781	0	201,535			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,104	0	0	53,050		8.00
9.00	00900	HOUSEKEEPING	60,229	0	0	0	243,831	9.00
10.00	01000	DIETARY	80,172	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,000	0	4,298	0	5,200	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,130,994	0	171,262	53,050	207,205	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	93,852	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,236	0	0	0	0	54.00
60.00	06000	LABORATORY	89,729	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	312,012	0	4,005	0	4,846	65.00
66.00	06600	PHYSICAL THERAPY	71,113	0	2,169	0	2,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,646	0	2,169	0	2,624	67.00
68.00	06800	SPEECH PATHOLOGY	30,138	0	2,156	0	2,608	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,868	0	15,476	0	18,724	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	425,462	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	77,272	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,640,608	0	201,535	53,050	243,831	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,640,608	0	201,535	53,050	243,831	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	324,570					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	0		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	324,570	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		324,570	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		324,570	0	0	0	0	202.00

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	
					RECREATIONAL THERAPY		
		15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	0					15.00
16.00	01600	0	260,499				16.00
17.00	01700	0	0	0			17.00
18.00	01850	0	0	0	0		18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	260,499	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		0	260,499	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	260,499	0	0	0	202.00

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Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
		20.00	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	RECREATIONAL THERAPY					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			0		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)				0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	9,643,751
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	379,953
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	207,426
60.00 06000	LABORATORY	0	0	0	0	363,261
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	1,272,007
66.00 06600	PHYSICAL THERAPY	0	0	0	0	292,689
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	242,218
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	126,776
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	175,359
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,722,449
74.00 07400	RENAL DIALYSIS	0	0	0	0	312,829
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	14,738,718
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	0	0	0	14,738,718

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	RECREATIONAL THERAPY		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,643,751
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	379,953
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	207,426
60.00	06000	LABORATORY	0	363,261
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,272,007
66.00	06600	PHYSICAL THERAPY	0	292,689
67.00	06700	OCCUPATIONAL THERAPY	0	242,218
68.00	06800	SPEECH PATHOLOGY	0	126,776
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	175,359
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,722,449
74.00	07400	RENAL DIALYSIS	0	312,829
76.97	07697	CARDIAC REHABILITATION	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0
76.99	07699	LITHOTRIpsy	0	0
OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,738,718
NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	14,738,718

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	118,196	0	118,196	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	0	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	21,753	0	21,753	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	866,773	0	866,773	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	20,272	0	20,272	65.00
66.00 06600	PHYSICAL THERAPY	0	10,978	0	10,978	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	10,978	0	10,978	67.00
68.00 06800	SPEECH PATHOLOGY	0	10,910	0	10,910	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	78,326	0	78,326	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,138,186	0	1,138,186	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,138,186	0	1,138,186	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	118,196					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,616	0	1,616			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	425	0	0	425		8.00
9.00	00900	HOUSEKEEPING	1,955	0	0	0	1,955	9.00
10.00	01000	DIETARY	2,603	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,013	0	34	0	42	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,186	0	1,375	425	1,661	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,047	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,663	0	0	0	0	54.00
60.00	06000	LABORATORY	2,913	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,130	0	32	0	39	65.00
66.00	06600	PHYSICAL THERAPY	2,309	0	17	0	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,904	0	17	0	21	67.00
68.00	06800	SPEECH PATHOLOGY	978	0	17	0	21	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,132	0	124	0	150	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,813	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,509	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,196	0	1,616	425	1,955	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	118,196	0	1,616	425	1,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet B Part II Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	2,603					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	0		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,603	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		2,603	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,603	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B
Part II
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE RECREATIONAL THERAPY	NONPHYSICIAN ANESTHETISTS	
	15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
6.00 00600						6.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
12.00 01200						12.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500	0					15.00
16.00 01600	0	23,842				16.00
17.00 01700	0	0	0			17.00
18.00 01850	0	0	0	0		18.00
19.00 01900	0	0	0	0	0	19.00
20.00 02000	0	0	0	0	0	20.00
21.00 02100	0	0	0	0	0	21.00
22.00 02200	0	0	0	0	0	22.00
23.00 02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	0	23,842	0	0		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	0	0	0		50.00
54.00 05400	0	0	0	0		54.00
60.00 06000	0	0	0	0		60.00
62.30 06250	0	0	0	0		62.30
65.00 06500	0	0	0	0		65.00
66.00 06600	0	0	0	0		66.00
67.00 06700	0	0	0	0		67.00
68.00 06800	0	0	0	0		68.00
71.00 07100	0	0	0	0		71.00
73.00 07300	0	0	0	0		73.00
74.00 07400	0	0	0	0		74.00
76.97 07697	0	0	0	0		76.97
76.98 07698	0	0	0	0		76.98
76.99 07699	0	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	0	0	0	0		99.10
99.20 09920	0	0	0	0		99.20
99.30 09930	0	0	0	0		99.30
99.40 09940	0	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS						
118.00						118.00
NONREIMBURSABLE COST CENTERS						
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	0	23,842	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
		20.00	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	RECREATIONAL THERAPY					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			0		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)				0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				965,865	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM				3,047	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				1,663	54.00
60.00 06000	LABORATORY				2,913	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	62.30
65.00 06500	RESPIRATORY THERAPY				30,473	65.00
66.00 06600	PHYSICAL THERAPY				13,325	66.00
67.00 06700	OCCUPATIONAL THERAPY				12,920	67.00
68.00 06800	SPEECH PATHOLOGY				11,926	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT				79,732	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS				13,813	73.00
74.00 07400	RENAL DIALYSIS				2,509	74.00
76.97 07697	CARDIAC REHABILITATION				0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY				0	76.98
76.99 07699	LITHOTRIPSY				0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF				0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY				0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY				0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY				0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,138,186	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	1,138,186	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet B Part II Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	RECREATIONAL THERAPY		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	965,865
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,047
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,663
60.00	06000	LABORATORY	0	2,913
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0
65.00	06500	RESPIRATORY THERAPY	0	30,473
66.00	06600	PHYSICAL THERAPY	0	13,325
67.00	06700	OCCUPATIONAL THERAPY	0	12,920
68.00	06800	SPEECH PATHOLOGY	0	11,926
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	79,732
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,813
74.00	07400	RENAL DIALYSIS	0	2,509
76.97	07697	CARDIAC REHABILITATION	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0
76.99	07699	LITHOTRIpsy	0	0
OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,138,186
NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	1,138,186

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	16,900				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		16,900			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,498,097		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,755	1,755	1,096,350	-3,640,608	11,098,110
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	0	0	0	151,754
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	39,946
9.00 00900	HOUSEKEEPING	0	0	0	0	183,602
10.00 01000	DIETARY	0	0	0	0	244,398
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	323	323	106,443	0	189,001
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
18.00 01850	RECREATIONAL THERAPY	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,870	12,870	3,817,138	0	6,496,171
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	286,101
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	655	0	156,190
60.00 06000	LABORATORY	0	0	0	0	273,532
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	301	301	362,885	0	951,144
66.00 06600	PHYSICAL THERAPY	163	163	90,398	0	216,783
67.00 06700	OCCUPATIONAL THERAPY	163	163	0	0	178,779
68.00 06800	SPEECH PATHOLOGY	162	162	0	0	91,874
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,163	1,163	24,228	0	106,291
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,296,987
74.00 07400	RENAL DIALYSIS	0	0	0	0	235,557
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	16,900	16,900	5,498,097	-3,640,608	11,098,110
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,138,186	0	848,077	3,640,608	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	67.348284	0.000000	0.154249	0.328039	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	118,196	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.010650	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	15,145				6.00
7.00	00700	OPERATION OF PLANT	0	15,145			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	9,582		8.00
9.00	00900	HOUSEKEEPING	0	0	0	15,145	9.00
10.00	01000	DIETARY	0	0	0	0	28,746
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	323	323	0	323	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
18.00	01850	RECREATIONAL THERAPY	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,870	12,870	9,582	12,870	28,746
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	301	301	0	301	0
66.00	06600	PHYSICAL THERAPY	163	163	0	163	0
67.00	06700	OCCUPATIONAL THERAPY	163	163	0	163	0
68.00	06800	SPEECH PATHOLOGY	162	162	0	162	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,163	1,163	0	1,163	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,145	15,145	9,582	15,145	28,746
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	0	201,535	53,050	243,831	324,570
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	13.307032	5.536422	16.099769	11.290962
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,616	425	1,955	2,603
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.106702	0.044354	0.129086	0.090552
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	0			13.00
14.00	01400	0	0	0	117,712		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	117,712	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		0	0	0	117,712	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		0	0	0	0	0	202.00
203.00		0.000000	0.000000	0.000000	0.000000	0.000000	203.00
204.00		0	0	0	0	0	204.00
205.00		0.000000	0.000000	0.000000	0.000000	0.000000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	
			RECREATIONAL THERAPY (TIME SPENT)			
	16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,181				16.00
17.00 01700	SOCIAL SERVICE	0	9,582			17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,181	9,582	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4,181	9,582	0	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	260,499	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	62.305429	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23,842	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.702464	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
	SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
18.00 01850	RECREATIONAL THERAPY				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	118.00
NONREIMBURSABLE COST CENTERS					
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet C
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	9,643,751		9,643,751	0	9,643,751	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	379,953		379,953	0	379,953	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,426		207,426	0	207,426	54.00
60.00	06000 LABORATORY	363,261		363,261	0	363,261	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,272,007	0	1,272,007	0	1,272,007	65.00
66.00	06600 PHYSICAL THERAPY	292,689	0	292,689	0	292,689	66.00
67.00	06700 OCCUPATIONAL THERAPY	242,218	0	242,218	0	242,218	67.00
68.00	06800 SPEECH PATHOLOGY	126,776	0	126,776	0	126,776	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175,359		175,359	0	175,359	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,722,449		1,722,449	0	1,722,449	73.00
74.00	07400 RENAL DIALYSIS	312,829		312,829	0	312,829	74.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0		0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00	Subtotal (see instructions)	14,738,718	0	14,738,718	0	14,738,718	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	14,738,718	0	14,738,718	0	14,738,718	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet C
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,484,840		13,484,840		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,341,315	0	1,341,315	0.283269	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,375,657	0	2,375,657	0.087313	54.00
60.00	06000	LABORATORY	1,568,428	0	1,568,428	0.231608	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	13,611,325	0	13,611,325	0.093452	65.00
66.00	06600	PHYSICAL THERAPY	382,859	0	382,859	0.764482	66.00
67.00	06700	OCCUPATIONAL THERAPY	388,702	0	388,702	0.623146	67.00
68.00	06800	SPEECH PATHOLOGY	699,144	0	699,144	0.181330	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,189,333	0	2,189,333	0.080097	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,000,191	0	2,000,191	0.861142	73.00
74.00	07400	RENAL DIALYSIS	652,889	0	652,889	0.479146	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	38,694,683	0	38,694,683		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	38,694,683	0	38,694,683		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet C Part I Date/Time Prepared: 1/24/2022 2:04 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.283269	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.087313	54.00
60.00	06000 LABORATORY	0.231608	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	0.093452	65.00
66.00	06600 PHYSICAL THERAPY	0.764482	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.623146	67.00
68.00	06800 SPEECH PATHOLOGY	0.181330	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.080097	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.861142	73.00
74.00	07400 RENAL DIALYSIS	0.479146	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699 LI THOTRI PSY	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF		99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY		99.40
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet C
Part I
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1/24/2022 2:04 pm

		Title XIX		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9,643,751	9,643,751	0	9,643,751	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	379,953	379,953	0	379,953	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,426	207,426	0	207,426	54.00
60.00	06000 LABORATORY	363,261	363,261	0	363,261	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,272,007	1,272,007	0	1,272,007	65.00
66.00	06600 PHYSICAL THERAPY	292,689	292,689	0	292,689	66.00
67.00	06700 OCCUPATIONAL THERAPY	242,218	242,218	0	242,218	67.00
68.00	06800 SPEECH PATHOLOGY	126,776	126,776	0	126,776	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175,359	175,359	0	175,359	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,722,449	1,722,449	0	1,722,449	73.00
74.00	07400 RENAL DIALYSIS	312,829	312,829	0	312,829	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
200.00	Subtotal (see instructions)	14,738,718	14,738,718	0	14,738,718	200.00
201.00	Less Observation Beds	0	0	0	0	201.00
202.00	Total (see instructions)	14,738,718	14,738,718	0	14,738,718	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet C
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,484,840		13,484,840			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,341,315	0	1,341,315	0.283269	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,375,657	0	2,375,657	0.087313	0.000000	54.00
60.00	06000	LABORATORY	1,568,428	0	1,568,428	0.231608	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	13,611,325	0	13,611,325	0.093452	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	382,859	0	382,859	0.764482	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	388,702	0	388,702	0.623146	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	699,144	0	699,144	0.181330	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,189,333	0	2,189,333	0.080097	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,000,191	0	2,000,191	0.861142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	652,889	0	652,889	0.479146	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	38,694,683	0	38,694,683			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	38,694,683	0	38,694,683			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet C Part I Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.283269			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.087313			54.00
60.00	06000 LABORATORY	0.231608			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.093452			65.00
66.00	06600 PHYSICAL THERAPY	0.764482			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.623146			67.00
68.00	06800 SPEECH PATHOLOGY	0.181330			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.080097			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.861142			73.00
74.00	07400 RENAL DIALYSIS	0.479146			74.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LI THOTRI PSY	0.000000			76.99
	OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet C
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	379,953	3,047	376,906	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,426	1,663	205,763	0	0	54.00
60.00	06000 LABORATORY	363,261	2,913	360,348	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,272,007	30,473	1,241,534	0	0	65.00
66.00	06600 PHYSICAL THERAPY	292,689	13,325	279,364	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	242,218	12,920	229,298	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	126,776	11,926	114,850	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175,359	79,732	95,627	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,722,449	13,813	1,708,636	0	0	73.00
74.00	07400 RENAL DIALYSIS	312,829	2,509	310,320	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
200.00	Subtotal (sum of lines 50 thru 199)	5,094,967	172,321	4,922,646	0	0	200.00
201.00	Less Observation Beds	0	0	0	0	0	201.00
202.00	Total (line 200 minus line 201)	5,094,967	172,321	4,922,646	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet C
Part II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX					
		Hospital		PPS	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	379,953	1,341,315	0.283269	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,426	2,375,657	0.087313	54.00
60.00	06000 LABORATORY	363,261	1,568,428	0.231608	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	1,272,007	13,611,325	0.093452	65.00
66.00	06600 PHYSICAL THERAPY	292,689	382,859	0.764482	66.00
67.00	06700 OCCUPATIONAL THERAPY	242,218	388,702	0.623146	67.00
68.00	06800 SPEECH PATHOLOGY	126,776	699,144	0.181330	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175,359	2,189,333	0.080097	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,722,449	2,000,191	0.861142	73.00
74.00	07400 RENAL DIALYSIS	312,829	652,889	0.479146	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0.000000	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
200.00	Subtotal (sum of lines 50 thru 199)	5,094,967	25,209,843		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	5,094,967	25,209,843		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part I Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	965,865	0	965,865	9,582	100.80	30.00
200.00	Total (lines 30 through 199)	965,865		965,865	9,582		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	5,276	531,821				
200.00	Total (lines 30 through 199)	5,276	531,821				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part II Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,047	1,341,315	0.002272	881,433	2,003	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,663	2,375,657	0.000700	1,409,659	987	54.00
60.00	06000	LABORATORY	2,913	1,568,428	0.001857	1,062,987	1,974	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	30,473	13,611,325	0.002239	7,748,365	17,349	65.00
66.00	06600	PHYSICAL THERAPY	13,325	382,859	0.034804	203,063	7,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,920	388,702	0.033239	203,377	6,760	67.00
68.00	06800	SPEECH PATHOLOGY	11,926	699,144	0.017058	377,096	6,433	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,732	2,189,333	0.036418	1,180,577	42,994	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,813	2,000,191	0.006906	1,142,471	7,890	73.00
74.00	07400	RENAL DIALYSIS	2,509	652,889	0.003843	340,232	1,308	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	172,321	25,209,843		14,549,260	94,765	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part III Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
200.00		Total (lines 30 through 199)	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS								
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	9,582	0.00	5,276	
200.00		Total (lines 30 through 199)	0	0	9,582		5,276	
INPATIENT ROUTINE SERVICE COST CENTERS								
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					
200.00		Total (lines 30 through 199)	0					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part IV Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description	Title XVIII		Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part IV Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Title XVIII		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				Total Charges (from Wkst. C, Part I, col. 8)					
	4.00	5.00	6.00	7.00	8.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	1,341,315	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,375,657	0.000000		54.00
60.00	06000	LABORATORY	0	0	0	1,568,428	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,611,325	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	382,859	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	388,702	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	699,144	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,189,333	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,000,191	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	652,889	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000		92.00
200.00		Total (lines 50 through 199)	0	0	0	25,209,843			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet D
Part IV
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	881,433	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,409,659	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	1,062,987	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	7,748,365	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	203,063	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	203,377	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	377,096	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,180,577	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,142,471	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	340,232	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		14,549,260	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part V Date/Time Prepared: 1/24/2022 2:04 pm
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Title XVIII		Hospital		PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00	06000 LABORATORY	0.000000	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part V Date/Time Prepared: 1/24/2022 2:04 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part I Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	965,865	0	965,865	9,582	100.80	
200.00	Total (lines 30 through 199)	965,865		965,865	9,582	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	0	0				
200.00	Total (lines 30 through 199)	0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part II Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,047	1,341,315	0.002272	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,663	2,375,657	0.000700	0	0	54.00
60.00	06000 LABORATORY	2,913	1,568,428	0.001857	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	30,473	13,611,325	0.002239	0	0	65.00
66.00	06600 PHYSICAL THERAPY	13,325	382,859	0.034804	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,920	388,702	0.033239	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	11,926	699,144	0.017058	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	79,732	2,189,333	0.036418	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	13,813	2,000,191	0.006906	0	0	73.00
74.00	07400 RENAL DIALYSIS	2,509	652,889	0.003843	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	172,321	25,209,843		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part III Date/Time Prepared: 1/24/2022 2:04 pm		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	9,582	0.00	0	30.00	
200.00		Total (lines 30 through 199)	0	0	9,582		0	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part IV Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description	Title XIX				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part IV Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
				Total Charges (from Wkst. C, Part I, col. 8)	PPS			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,341,315	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,375,657	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,568,428	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,611,325	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	382,859	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	388,702	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	699,144	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,189,333	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,000,191	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	652,889	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	25,209,843		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet D
Part IV
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet D
Part V
Date/Time Prepared:
1/24/2022 2:04 pm

		Title XIX		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.283269	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087313	0	0	0	0	54.00
60.00	06000	LABORATORY	0.231608	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.093452	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.764482	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.623146	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.181330	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.080097	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.861142	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.479146	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part V Date/Time Prepared: 1/24/2022 2:04 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/24/2022 2:04 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,582	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,582	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,582	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		5,276	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,643,751	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,643,751	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,643,751	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,006.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,309,977	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,309,977	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/24/2022 2:04 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)				42.00	
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT				43.00	
44.00	CORONARY CARE UNIT				44.00	
45.00	BURN INTENSIVE CARE UNIT				45.00	
46.00	SURGICAL INTENSIVE CARE UNIT				46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00	
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				2,934,824	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				8,244,801	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				531,821	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				94,765	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				626,586	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				7,618,215	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D-1 Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	965,865	9,643,751	0.100154	0	0	90.00
91.00	Nursing School cost	0	9,643,751	0.000000	0	0	91.00
92.00	Allied health cost	0	9,643,751	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,643,751	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/24/2022 2:04 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,582	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,582	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,582	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,643,751	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,643,751	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,643,751	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,006.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description			Title XIX		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2025		Period: From 09/01/2020 To 08/31/2021		Worksheet D-1 Date/Time Prepared: 1/24/2022 2:04 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	965,865	9,643,751	0.100154	0	0	90.00
91.00	Nursing School cost	0	9,643,751	0.000000	0	0	91.00
92.00	Allied health cost	0	9,643,751	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,643,751	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,386,400		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.283269	881,433	249,683	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.087313	1,409,659	123,082	54.00
60.00	06000 LABORATORY	0.231608	1,062,987	246,196	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.093452	7,748,365	724,100	65.00
66.00	06600 PHYSICAL THERAPY	0.764482	203,063	155,238	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.623146	203,377	126,734	67.00
68.00	06800 SPEECH PATHOLOGY	0.181330	377,096	68,379	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.080097	1,180,577	94,561	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.861142	1,142,471	983,830	73.00
74.00	07400 RENAL DIALYSIS	0.479146	340,232	163,021	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRIPTY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		14,549,260	2,934,824	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		14,549,260		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/24/2022 2:04 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.283269	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.087313	0	0	54.00
60.00	06000 LABORATORY	0.231608	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.093452	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.764482	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.623146	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.181330	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.080097	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.861142	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.479146	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet E-1
Part I
Date/Time Prepared:
1/24/2022 2:04 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,687,767		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/31/2021	243,170		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		243,170		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,930,937		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		23,269		0		6.02
7.00	Total Medicare program liability (see instructions)		10,907,668		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-2025	Period: From 09/01/2020 To 08/31/2021	Worksheet E-3 Part IV Date/Time Prepared: 1/24/2022 2:04 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			11,034,039 1.00
1.01	Full standard payment amount			9,011,360 1.01
1.02	Short stay outlier standard payment amount			2,022,679 1.02
1.03	Site neutral payment amount - Cost			0 1.03
1.04	Site neutral payment amount - IPPS comparable			0 1.04
2.00	Outlier Payments			135,751 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			11,169,790 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			0 5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)			0 6.00
7.00	Subtotal (see instructions)			11,169,790 7.00
8.00	Primary payer payments			0 8.00
9.00	Subtotal (line 7 less line 8)			11,169,790 9.00
10.00	Deductibles			97,795 10.00
11.00	Subtotal (line 9 minus line 10)			11,071,995 11.00
12.00	Coinsurance			384,228 12.00
13.00	Subtotal (line 11 minus line 12)			10,687,767 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			338,309 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			219,901 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			217,957 16.00
17.00	Subtotal (sum of lines 13 and 15)			10,907,668 17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 18.00
19.00	Other pass through costs (see instructions)			0 19.00
20.00	Outlier payments reconciliation			0 20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 21.50
21.99	Demonstration payment adjustment amount before sequestration			0 21.99
22.00	Total amount payable to the provider (see instructions)			10,907,668 22.00
22.01	Sequestration adjustment (see instructions)			0 22.01
22.02	Demonstration payment adjustment amount after sequestration			0 22.02
23.00	Interim payments			10,930,937 23.00
24.00	Tentative settlement (for contractor use only)			0 24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)			-23,269 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)			135,751 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet G

Date/Time Prepared:
1/24/2022 2:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-108,176	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	125,320	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	205,374	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	222,518	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	110,439	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,240,804	0	0	0	23.00
24.00	Accumulated depreciation	-1,002,991	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,223,282	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,571,534	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	180,200	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	180,200	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,974,252	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,821,215	0	0	0	37.00
38.00	Salaries, wages, and fees payable	295,798	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,117,013	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	24,957	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,957	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,141,970	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	832,282	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	832,282	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,974,252	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-1

Date/Time Prepared:
1/24/2022 2:04 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		3,203,214		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,035,496			2.00
3.00	Total (sum of line 1 and line 2)		7,238,710		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		7,238,710		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,238,710		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/24/2022 2:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	13,484,840		13,484,840	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,484,840		13,484,840	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,484,840		13,484,840	17.00
18.00	Ancillary services	25,209,843	0	25,209,843	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	38,694,683	0	38,694,683	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,258,698		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,258,698		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-3

Date/Time Prepared:
1/24/2022 2:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	38,694,683	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,058,218	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,636,465	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,258,698	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,377,767	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	177	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	191	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	657,361	24.50
25.00	Total other income (sum of lines 6-24)	657,729	25.00
26.00	Total (line 5 plus line 25)	4,035,496	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,035,496	29.00